Maricopa Integrated Health System
Health Plans
CRS Client Referral Form

Client Name: _____DOB:_____

AHCCCS Number: _____

P.I.D. Number: _____

Family Health Center: _____

Primary Care Physician: _____

Contact Person: (parent) _____

Family's address/phone: _____

Diagnosis: _____

Additional Information: _____

_____

_____

Please Send This Form by Interoffice Mail or Fax to: (Only if a CRS applic. has been sent/faxed to CRS)

Elena Garcia RN, CRS Coordinator
Maricopa Intergrated Health System
2502 E. University Dr. Ste 202, Phx, 85034
Fax: 602-344-8909/ phone: 602-344-8907

***This is <u>NOT</u> a CRS Application !**